Systems Linkage Workgroup Notes
June 25, 2012

Individuals expressed that all factors discussed below are critical for an ideal behavioral health system.

I. General
   a. Parity
   b. Prevention and early identification
   c. Recovery-focused
   d. Consumer- and family-friendly
   e. Protection of behavioral health funding and services

   Notes:
   - Maryland regulations passed in the 90s to achieve parity might be antiquated, in some instances goal is to go beyond parity
   - Waiver program requirements do not allow for prevention and early identification. Once a waiver is needed, opportunity for prevention and early identification is gone so in that respect, the latter should be prioritized.
   - Enforcement is a huge barrier to parity.
   - "Parity" needs to be more clearly defined, and its wide applicability in different systems needs to be acknowledged. Consumers and their families are not aware of their rights under parity and don't have a clear, easy way to argue when parity isn't being upheld
   - Parity shouldn't be an issue after integration, because the outcomes should assess whether or not the system is meeting the needs of the whole consumer
   - There are more barriers to parity and protection of behavioral health dollars and services under Model 1. Specialized systems of care for behavioral health populations are better with regard to these components.
   - Funding needs to be flexible to allow for dollars to be allocated to prevention and early identification
   - Under the current SUD plan, most recovery services aren't funded, such as case management and follow-up support although these services are critical for individuals with substance use disorders. This needs to change, and the philosophy, regulations, and funding structure need to be aligned.
   - There are more barriers in Model 1 with regard to prevention, recovery-focused, and consumer- and family-centered treatment, as a more skilled, focused organization would be better about to prioritize for populations with high behavioral health needs
   - Customer service in general is different for the behavioral health rather than the general population; this population generally needs more specific, guided assistance.
   - There may not be sufficient savings on the behavioral health side to cover the additional administrative burden.

II. Managed Care Functions
   a. Access
   b. Utilization management
   c. Claims processing, payment, and FFP
   d. Data collection and management information systems
   e. Public information and training
   f. Compliance, fraud, and abuse

g. Evaluation
h. Outcomes measurement
i. Provider network development and monitoring

Notes:

- Look at utilization management guidelines to determine what they're focused on
- Determine what data is needed to select a model and for outcomes regarding management information systems
- The training needs to be clear and directed at its target audience
- Training should come from a central source, such as the State, and not from each MCO or BHO, to ensure uniformity and consistency
- Provider networks need to be developed in a way that allow for quality control and continued monitoring
- Regarding access, the special needs of behavioral health populations may not be adequately addressed in an MCO setting
- There are currently 7 MCOs with 7 separate systems, and providers have to comply with the different systems
- It varies who has access to MCO data, and all organizations involved in providing services to the behavioral health population should have shared priorities
- There need to be incentives for providers to collect data; currently, data collection is not enforced
- Duplicative and extensive audits by multiple levels of an organization should be addressed
- Need to keep in mind that SUD data is usually self-reported and, therefore, may be weak. Hard tests, such as blood tests, should be done to improve accuracy.
- Under the ASO models, providers get some data but they need access to it all to treat the person as a whole person.
- Under Model 1, seven MCOs with seven different contacts would make utilization management and data collection very difficult. One ASO/BHO-type model would be preferable.
- EHRs won't necessarily solve the problem because there are different EHRs in different systems. If providers are going to be required to establish expensive EHRs, they should: (a) be provided funding support, and (b) have one database into which all data can be accessed and stored to improve the value proposition of adopting an EHR.
- When conducting outcomes measurement, need to keep in mind that providers see vastly different populations. This needs to be kept in mind as providers are being assessed, such that providers aren't penalized for serving a challenging population. One potential solution is risk adjusting target outcomes based on the individual or sub-population.
- Model 2 may be a barrier to outcomes measurement because it may lead to finger-pointing; i.e. two entities responsible for the care of one person may mean no entity ends up responsible for poor outcomes.
- If Model 2 is selected, perhaps one agency should oversee the MCO and BHO
- Buy software from old ASO and hand over to new ASO to improve transitions
- Provider network development should include protections for historic providers; any willing provider not working when some of these organizations are not operating judiciously

III. Special Functions
   a. MA Waivers
   b. Accountable Care Organizations
   c. Health homes
   d. Advisory boards
   e. Oversight boards

   Notes:
   - It would be better to entitle people onto a waiver earlier than to wait and have to "look for a slot"
   - Health home efforts that focus on child and adolescent specialization should be careful not to separate services from the family
   - There need to be consumer representatives on advisory and oversight boards from the fields of mental health, substance use, and consumers of both

IV. Risk Sharing: Pay for Performance
   a. Finance level
   b. Service level
   c. Evidence-based practice
   d. Capitation

   Notes:
   - Providers should be able to contract in different financial arrangements (e.g. fee-for-service, capitation, etc)
   - The rate-setting process needs to be more mindful
   - Both positive and negative incentives should be in place to control costs and improve quality
   - Evidence-based practices should be used to test model fidelity

V. Integration of Care Efforts
   a. Coordination of care at a system level
   b. Coordination of care at a service delivery level
   c. Coordination of care at a consumer level
   d. Integration of care at a system level
   e. Integration of care at a delivery level
   f. Universal pharmacy information available
   g. Coordinate with Exchange

   Notes:
   - There are three levels of coordination and a system should do all three for behavioral health consumers: (1) intensive care management; (2) partnership between behavioral and physical health service providers; (3) fully-integrated, co-located behavioral and physical health service providers
   - Should look at how many providers currently serve both Medicaid and private populations to get a sense of care continuity
   - System should actively educate consumers on their care, using a combination of pre-prepared materials and representatives (Navigators), at a level that can easily be understood; consumer understanding is particularly an issue at the time of intake

- Consider allowing consumers to pick their health home, whether predominately somatic or behavioral health-focused; an individual who is low functioning mentally may default to behavioral health home

VI. Technology
   a. System
   b. Provider
   c. Consumer
   d. Telemedicine services

Notes:
- Behavioral health providers need financial support to implement new technologies
- The technology developed and enforced should be related to whichever data elements need to be collected in order to assess outcomes, conduct evaluations, and allow for risk-sharing
- Behavioral health providers should be able to access data through CRISP
- Consumers and providers should take advantage of the availability of advanced directives

VII. Rate Setting
   a. Transparency with stakeholder participation
   b. Methodology and results available on web to public
   c. HSCRC
   d. FQHC

Notes:
- The flexibility of the rate setting process (especially to "unknowns") is critical to providers' survival
- Without including stakeholders in the rate setting process, it is hard to compute develop a rate transparently
- Having rates available in COMAR may not be transparent enough

VIII. Partners

DHMH - Medicaid	Corrections	New BHA (MHA/ADAA)
DHR	DHMH – Public Health and LHDs	Dept. of Rehabilitative Services
DHMH – IT	Dept. of Aging	HUD
CSAs	Provider associations	MDOT
MHCC	Consumer associations	VA
CMS	Family associations	Dept. of Defense
GOC	Dept. of Juvenile Services	SSA
DDA	SAMHSA	Financial Institutions
Dept. of Disability	Academic institutions	Dept. of Housing and Community Development
Judiciary	Plan/advisory boards	

Notes:

- Need to make partners aware of these changes and give them the opportunity to comment
- Partners are both funders and facilitators and these relationships need to be protected and cultivated
- The more specialized the system, the more able our partners are able to inform and lend their guidance; as such, partnerships may be most strained under Model 1

IX. General Notes:

- People will need help figuring the system out and navigating it. Especially at the first point of entry into the system, consumers and their families need to be educated.
- Don't lose the linkages that currently exist and work so well, such as the linkage between the detention and behavioral health systems with pharmacy data.
- Avoid separating child from adult services for the sake of family and life continuity
- The advantage of an ASO model is it specializes in the additional needs of behavioral health consumers, identifying them and making sure they're met.
- Consider a stepwise approach to transforming the system. It is dangerous to change everything at once. Special populations need special protections, and moving slowly and conducting progressive evaluation could be smart.